



FACTS

Bridging the Gap

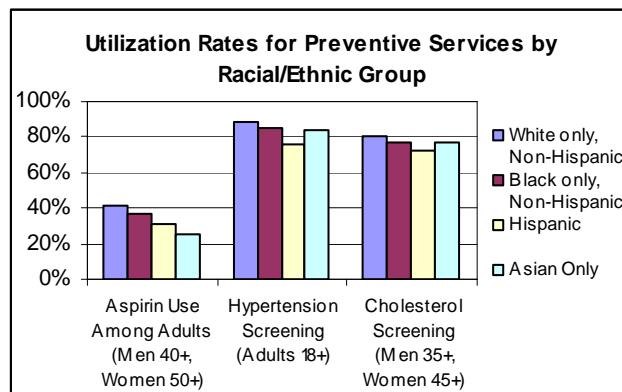
CVD Health Disparities

Racial and ethnic health care disparities could well determine whether a person will suffer or survive a heart attack or stroke. Cardiovascular disease (CVD), including heart disease and stroke, remains the No. 1 killer of Americans¹, and exacts a disproportionate toll on many racial and ethnic groups² that have higher rates of CVD and related risk factors. Yet ironically, these very populations confront more barriers to CVD diagnosis and care, receive lower quality treatment and experience worse health outcomes than their white counterparts.³ Such disparities are linked to a number of complex factors, such as income and education, genetic and physiological factors, access to care, and communication barriers.^{4,3} The American Heart Association (AHA) believes that it is time to bridge the disparity gap and provide quality health care for all who live in the United States.

GREATER RISKS, GREATER DEATHS

Many racial/ethnic minority populations have higher rates of CVD and related risk factors. The statistics are stark testimony to that fact.

- Coronary heart disease death rates are higher for black males and females than their white counterparts.¹
- Blacks are nearly twice as likely to have a first stroke and 1.8 times more likely to die from one than whites.¹
- High blood pressure is more prevalent in certain racial/ethnic minority groups, especially blacks.¹
- Non-Hispanic blacks, Mexican-Americans, American Indians, and Alaska Natives have a higher prevalence of diabetes than non-Hispanic whites for adults over age 20.¹
- African-American women and Mexican Americans have a higher rate of obesity, a risk factor for CVD and diabetes.¹



Source: Partnership for Prevention. *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, 2007.

LOWER ACCESS, LOWER QUALITY

Racial/ethnic minority groups more frequently lack health insurance and have limited access to quality health care.⁶ Many people are also unaware that health disparities even exist.

- A 2007 U.S. Census Bureau report showed that blacks, Asians, Hispanics, American Indians, Alaska Natives, Native Hawaiians and other Pacific Islanders are more likely to be uninsured.⁷
- A recent survey found that Hispanics and blacks are less likely than whites to have access to a regular source of medical care, but disparities in access and quality can be reduced or eliminated by having health insurance and a medical home.⁸
- A recent report on cardiac care quality for racial/ethnic groups found evidence of disparities in 84% of the studies examined.⁹
- Evidence suggests black adults are far more likely than white adults to be admitted to the hospital for angina and congestive heart failure.¹⁰
- A study on cardiovascular procedures found blacks were more likely than whites to be admitted to an emergency room and had higher post-operative mortality rates.¹¹
- Disparities are also linked to minority patients receiving care in lower-performing hospitals.¹²
- A recent poll revealed that 56% of Hispanics and 44% of African Americans believe minorities receive inferior care as compared to whites, but only 25% of whites agreed.¹³

HEALTH CARE WORKFORCE

There are fewer minority physicians and limited awareness among cardiovascular practitioners about health care disparities.

- Minorities are greatly underrepresented in the U.S. physician workforce. In 2001, only 2% of cardiologists were black, 3.8% were Hispanic, and 12.7% were Asian.¹⁴
- In 2004, almost two-thirds of U.S. medical school graduates were white. Only 6.3% were black, 6.2% were Hispanic/Latino, and less than 1% were Native American.¹⁵
- Many minority patients have difficulty communicating with their health care providers.⁶
- Just 35% of cardiologists recently surveyed agreed that disparities in overall care exist in the U.S., and only 5% believed disparities exist in the care of their own patients.¹⁶

MORE AND BETTER DATA NEEDED

- A recent review of racial/ethnic differences in cardiac care showed that 91% of high quality studies included data on blacks, but only 26% on Hispanics, 14% on Asians, and a mere 5% on Native Americans.⁹
- The proportion of people in the U.S. who are members of at least two ethnic groups will increase 10% by the year 2050, complicating assessments of health disparities.¹⁷
- No standardized requirement exists in the health care industry for collecting, categorizing or using race/ethnicity data.⁶

2003 Minority Health Summit

In 2003, the AHA convened a 3-day summit to examine CVD health care disparities and assist in developing the next phase of the AHA's scientific, programmatic, and advocacy agendas addressing these issues. The recommendations included:⁴

- Increase research on genetic and environmental factors that contribute to racial/ethnic health disparities and increase the participation of minorities in research and as investigators
- Increase the number of racial/ethnic minorities who work in health care and improve cultural competency among health care providers
- Oppose genetic discrimination and support increased federal funding to address health disparities
- Increase CVD screening and prevention
- Improve minority access to quality care
- Stratify and report data by racial/ethnic groups
- Increase public education about disparities

WE MUST DO MORE

The AHA and its American Stroke Association division advocate for passage of legislation to eliminate disparities in health care, including:

- *The Minority Health Improvement and Health Disparity Elimination Act of 2007 (S.1576/H.R. 3333)* and *the Health Equity and Accountability Act (H.R. 3014)* would increase health care workforce diversity and competence, promote health care access and awareness among minorities, further research, and create a national plan to reduce/eliminate health disparities.
- *The Indian Health Care Improvement Act of 2007 (S. 1200/H.R. 1328)* would help reduce heart disease and stroke disparities among Native Americans and Alaska Natives.
- Bills promoting health information technology use would help reduce health disparities and ensure patients with CVD receive recommended care. The AHA/ASA has demonstrated that clinical decision support tools, such as its *Get With The Guidelines* hospital-based national quality improvement program, can help improve the quality of care that coronary artery disease, heart failure, and stroke patients receive.

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